Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Steven Sacks, MD

Respondent Name
Metropolitan Transit Authority

MFDR Tracking Number
M4-14-2632-01

Carrier's Austin Representative
Box Number19

MFDR Date Received
April 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies per Rule 133.250:"

Amount in Dispute: $235.27

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 6, 2013	99203, 95886, 95913, A4556	$235.27	$176.14

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.10 sets out procedures for designated doctor examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 185 – Payment denied/reduced for absence of, or exceeded referral
   - 193 – Original payment decision is being maintained
   - P14 – The benefit for this service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Was prior authorization exceeded?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §127.10(c) states in pertinent part, "The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements…" Therefore, the disputed services will be reviewed per applicable rules and fee guidelines. These calculations are as follows:
    - Procedure code 99203, service date December 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 1.42 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 1.43278. The practice expense (PE) RVU of 1.62 multiplied by the PE GPCI of 1.002 is 1.62324. The malpractice RVU of 0.14 multiplied by the malpractice GPCI of 0.923 is 0.12922. The sum of 3.18524 is multiplied by the Division conversion factor of $55.30 for a MAR of $176.14.
    - Procedure code 95886, service date December 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.7 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.7063. The practice expense (PE) RVU of 1.76 multiplied by the PE GPCI of 1.002 is 1.76352. The malpractice RVU of 0.03 multiplied by the malpractice GPCI of 0.923 is 0.02769. The sum of 2.49751 is multiplied by the Division conversion factor of $55.30 for a MAR of $138.11 at 4 units is $552.44.
    - Procedure code 95913, service date December 6, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 3.56 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 3.59204. The practice expense (PE) RVU of 5.12 multiplied by the PE GPCI of 1.002 is 5.13024. The malpractice RVU of 0.21 multiplied by the malpractice GPCI of 0.923 is 0.19383. The sum of 8.91611 is multiplied by the Division conversion factor of $55.30 for a MAR of $493.06.
    - Procedure code A4556, service date December 6, 2013, is a bundled code and not separately payable.
2. The total allowable reimbursement for the services in dispute is $1,221.64. This amount less the amount previously paid by the insurance carrier of $1,045.50 leaves an amount due to the requestor of $176.14. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $176.14.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $176.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	July , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.